Use of PCA morphine as the sole analgesic for postoperative pain relief after TAH

Editor—We were concerned by the comment in the introduction to the paper by Dr Ng and colleagues1 that their current postoperative analgesic regime following total abdominal hysterectomy (TAH), which was given to the control group, comprises solely morphine by patient controlled analgesia (PCA) device. The benefits of combinations of analgesics have been known for some time,2–4 and we believe that the control patients received an analgesic regimen that many practising anaesthetists would consider to be less than ideal. It is our routine practice also to use simple analgesics postoperatively whenever opiates are prescribed postoperatively.

P. Sigston
D. Yates
S. Leonardi
Timbridge Wells, UK

Editor—We acknowledge that in some studies of pain relief after TAH analgesic adjuncts5–7 may reduce the total dose of opioid required postoperatively; this may produce modest improvements in analgesia and reduce effects such as sedation and nausea. However, in other studies beneficial effects have not been demonstrated.5–6 In our study,1 patients were allowed to self-titrate morphine to match their analgesic requirements and clearly those who received placebo used more morphine that those who had parecoxib. There were no differences in pain scores at rest or on inspiration and we did not find any significant difference in sedation, nausea, or the use of antiemetics between the two treatment groups.

Evidence from the literature suggests that patients receive adequate analgesia solely with morphine by PCA. In another study7 in patients who had TAH, the highest mean (SD) postoperative pain visual analogue scores (VAS 0–100 mm Hg) at rest and on movement were 36 (5.3) and 50 (6.3) mm in patients without analgesic adjuncts, and the use of local anaesthetics by intraperitoneal administration did not improve analgesia. In another study post TAH, Leung9 showed that mean pain verbal rating scores (VRS 0–10) were less than 3 on awakening and that the majority of mean VRS scores in the placebo group who received only morphine for the remainder of the postoperative period were less than 5. Again local anaesthesia by infiltration had no significant effect on analgesia. In another study comparing acetaminophen, diclofenac and placebo administered to patients using morphine by PCA after TAH, Cobby9 was not able to demonstrate any significant difference in pain scores between the three groups. The average median (range) VAS pain score was 26 (3–56) mm in the placebo group. After abdominal surgery, Hodsman and colleagues10 showed that the highest mean (SEM) postoperative pain VAS score in patients who received placebo was 40 (4) mm. In another trial in which patients received morphine by PCA with no analgesic adjuncts, Stanley11 reported that the highest mean (SEM) postoperative VAS was 45.2 (6.8) mm after TAH.

In conclusion, the evidence does not support Drs Sigston, Yates and Leonardi’s contention that the use of PCA alone without analgesic adjuncts represents substandard analgesia and consequently the study protocol was passed without demur by our Local Research Ethics Committee. We totally reject the implication that our patients in the placebo group were given inadequate analgesia in order to attempt to demonstrate superiority of a test drug.

A. Ng
G. Smith
Leicester, UK

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